# EUTF ACTIVES

## Medical Plan Coverage Chart (HMSA, Kaiser, RSN) - EUTF

| Plan Design | EUTF 90/10 PPO Plan | | EUTF 80/20 PPO Plan | |
|---|---|---|---|---|
| **Carrier** | **HMSA** | | **HMSA** | |
| **General** | In-Network | Out-of-Network* | In-Network | Out-of-Network* |
| Calendar Year Deductible Single/Family | None | $100 per person; $300 per family | None | |
| Calendar Year Maximum Out-of-Pocket Single/Family | $2,000/$4,000 | | $2,500/$5,000 | |
| Lifetime Benefit Maximum | None | | None | |
| Plan Year Benefit Maximum | None | | None | |
| **Physician Services** | **YOU PAY*:** | | **YOU PAY*:** | |
| Primary Care Office Visit | 10% | 30% | $14 | $14 |
| Specialist Office Visit | 10% | 30% | $14 | $14 |
| Routine physical exams | No Charge | No Charge** | No Charge | No Charge |
| Screening Mammography | No Charge | 30%** | No Charge | No Charge |
| Immunizations | No Charge | No Charge** | No Charge | No Charge |
| Well Baby Care Visits | No Charge | 30%** | No Charge | No Charge |
| Maternity | Same as any other condition | Same as any other condition | 10% | 10% |
| Second opinion – surgery | 10% | 30% | $14 | $14 |
| Emergency Room (ER care) | 10% | 10%** | $20 | $20 |
| Ambulance | 10% | 30% | 20% | 20% |
| **Inpatient Hospital Services** | | | | |
| Room & Board | 10% | 30% | 20% | 20% |
| Ancillary Services | 10% | 30% | 20% | 20% |
| Physician services | 10% | 30% | $20 | $20 |
| Surgery | 10% | 30% | 20% | 20% |
| Anesthesia | 10% | 30% | 20% | 20% |
| **Outpatient Services** | | | | |
| Chemotherapy/ Radiation Therapy | 10% | 30% | 20% | 20% |
| Surgery | 10% | 30% | 20% | 20% |
| Diagnostic Lab | 10% | 30% | No Charge | No Charge |
| Diagnostic X-ray | 10% | 30% | 20% | 20% |
| Anesthesia | 10% | 30% | 20% | 20% |
| **Mental Health Services** | | | | |
| Inpatient Care | 10% | 30% | 20%, Facility Services | 20%, Facility Services |
| Outpatient Care | 10% | 30% | 20%, Facility Services | 20%, Facility Services |
| **Other Services** | | | | |
| Durable Medical Equipment | 10% | 30% | 20% | 20% |
| Home Health Care | No Charge | 30% | 20% | 20% |
| Hospice Care | No Charge | Not Covered | No Charge | No Charge |
| Nursing Facility - Skilled Care | 10%, 120 days/CY | 30%, 120 days/CY | 20%, 120 days/CY | 20%, 120 days/CY |
| Physical & Occupational Therapy | 10% | 30% | 20% | 20% |
| **Notes:** | * If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment plus any difference between the actual charge and the eligible charge.<br><br>**Deductible does not apply<br><br>For prescription drug coverage, refer to the PPO plan on page 24. | | * If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment plus any difference between the actual charge and the eligible charge.<br><br>For prescription drug coverage, refer to the PPO plan on page 24. | |